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The Patient Protection and Affordable Care Act: The Latest Obstacle in the Path to Receiving Complementary and Alternative Health Care?

CHELSEA STANLEY*

INTRODUCTION

In 2004, Diane Klenke was diagnosed with pancreatic cancer and given three months to live.¹ Klenke chose to be treated at the Block Center for Integrative Care, which specializes in integrative health care—traditional approaches alongside alternative and complementary therapies.² After undergoing chemotherapy along with complementary and alternative nausea, nutrition, and stress-management therapies, Klenke’s cancer went into remission and has stayed that way.³ Klenke worked with the Block Center to successfully persuade her insurance company to cover her entire course of treatment and follow-up treatments, including the complementary and alternative approaches she chose.⁴ Despite a growing demand for such integrative care and a resultant increase in insurance coverage of alternative and complementary treatments, as one author reported, the “Path to Alternative Therapies [Remains] Littered with Obstacles.”⁵

The complementary and alternative health-care sector of the United States has experienced widespread growth in the past decade.⁶ Market growth has been fueled by a trend among patients toward alternative practices that are believed to be less costly, more in line with patient values, and more capable of easing pains associated with illnesses that cannot be cured by traditional medicine.⁷ Consequently, various complementary and alternative disciplines are being practiced more widely throughout the United States.⁸

The market for complementary and alternative medicine (CAM) is also benefitting from changes in the insurance landscape. An increasing number of employers now cover alternative health-care options pursued by their employees.⁹

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1. Diane Klenke, *Patient Stories: Diane Klenke*, BLOCKCENTER, http://www.blockmd.com/patient_stories/4.

2. Walecia Konrad, *Path to Alternative Therapies Is Littered with Obstacles*, N.Y. TIMES (Nov. 13, 2009), http://www.nytimes.com/2009/11/14/health/14patient.html?_r=0.

3. *Id.*

4. *Id.*

5. *Id.*

6. E.g., NAT’L CTR. FOR COMPLEMENTARY & ALTERNATIVE MED., THE USE OF COMPLEMENTARY AND ALTERNATIVE MEDICINE IN THE UNITED STATES (2008), available at <http://nccam.nih.gov/sites/nccam.nih.gov/files/camuse.pdf>.

7. Setareh Tais & Erica Oberg, *The Economic Evaluation of Complementary and Alternative Medicine: The Growing Importance of Including Naturopathic Doctors in Healthcare Reform*, NAT. MED. J. (Feb. 2013), http://www.naturalmedicinejournal.com/article_content.asp?edition=1§ion=2&article=402.

8. See NAT’L CTR. FOR COMPLEMENTARY & ALTERNATIVE MED., *supra* note 6.

9. Compare KAISER FAMILY FOUND. & HEALTH RESEARCH & EDUC. TRUST, EMPLOYER HEALTH BENEFITS: 2002 ANNUAL SURVEY 108 (2002) (thirty-two percent of surveyed workers

Many proponents of alternative care have expressed enthusiasm that policies sold on health-care exchanges pursuant to the Patient Protection and Affordable Care Act, commonly referred to as the Affordable Care Act (ACA) or “Obamacare,” will also cover alternative-care options.¹⁰ Despite valid supporting argumentation, this Note argues that such enthusiasm may be overstated and premature because counterarguments suggest that CAM will be adversely affected by the new legislation. The language of the ACA, which includes mechanisms for both stimulating CAM development and impairing the CAM system, has thus created a battleground for the latest installment of verbal and political warfare between proponents and opponents of alternative care.¹¹ Federal and state regulators should seriously consider the arguments raised in such discourse in order to properly interpret and enforce the relevant ACA provisions.

Part I of this Note outlines a variety of medical techniques that are considered to be complementary and alternative practices, and it presents evidence of CAM’s growing influence in the United States. Part I also provides a concise summary of some of the most important features of the ACA. Part II analyzes the potential impact of the ACA on CAM. Part II focuses first on those provisions of the ACA that are believed to be supportive of CAM; however, Part II then proposes potential counterarguments ignored or overlooked by those who believe that the ACA will favorably impact CAM. Part III outlines the importance of advocacy in this battle between competing interpretations of the ACA and ultimately suggests that the ACA should be interpreted and enforced in a manner that takes both understandings into consideration.

had a plan that covered acupuncture), with KAISER FAMILY FOUND. & HEALTH RESEARCH & EDUC. TRUST, EMPLOYER HEALTH BENEFITS: 2004 ANNUAL SURVEY 106 (2004) (forty-seven percent of surveyed workers had a plan that covered acupuncture).

10. E.g., Kaiser Health News & Ankita Rao, *Alternative Treatments Could See Wide Acceptance Thanks to Obamacare*, PBS NEWSHOUR (July 29, 2013, 9:38 AM), <http://www.pbs.org/newshour/rundown/2013/07/how-the-health-reform-law-will-impact-alternative-medicine-access.html>.

11. For example, during his twenty-five years as secretary of the American Medical Association (AMA) and editor of the *Journal of the American Medical Association*, Morris Fishbein called chiropractors “killers” and led an active antichiropractic campaign. Even after Fishbein’s removal, the AMA continued its push for the elimination of chiropractic. See, e.g., RICHARD DEANDREA & JOHN WOOD, BREAKTHROUGH CURES: REVOLUTIONARY ANSWERS TO THE DEADLIEST DISEASES 27 (2010); *Dr. Morris Fishbein Dead at 87; Former Editor of A.M.A. Journal*, N.Y. TIMES, Sept. 28, 1976, at 42. The AMA has also been accused of trying to buy out Harry Hoxsey, a developer of a purported herbal remedy for cancer. When he refused the buyout, the AMA allegedly caused the clinician to be arrested 125 times in sixteen months. “The AMA, NCI (National Cancer Institute), and FDA organized a ‘conspiracy’ to ‘suppress’ a fair, unbiased assessment of Hoxsey’s methods, according to a 1953 report to Congress.” DEANDREA & WOOD, *supra*, at 29–30. As a last example, the AMA has been accused of conspiring to shut down the practice of homeopathy. To support such an accusation, proponents cite to the fact that in 1900, there were twenty-two homeopathic medical schools, one hundred homeopathic hospitals, and over one thousand homeopathic pharmacies in the United States. However, in 1918, eight years after an AMA report criticized the practices, only seven homeopathic medical schools remained in existence. *Id.* at 27.

I. THE RISE OF COMPLEMENTARY AND ALTERNATIVE MEDICINE AND THE
INTRODUCTION OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT

A. What Is Complementary and Alternative Medicine?

CAM is a term that encompasses a vast array of practices, procedures, and products that are not currently accepted as mainstream, orthodox medicine but that are nevertheless used to treat human ailments.¹² CAM approaches are not part of conventional medicine because there is insufficient proof that they are safe and effective.¹³ Although there are numerous types of CAM, some of the most popular and well-known types include homeopathy, chiropractic, acupuncture, naturopathy, massage therapy, and meditation.¹⁴

Homeopathy involves treating an individual with highly diluted substances in hopes of triggering the body's natural system of healing.¹⁵ The underlying principle of such a practice is that ailments can be treated "like with like."¹⁶ In other words, a substance that causes symptoms when taken in relatively large quantities will be diluted in order to serve as a treatment for those same symptoms.¹⁷ For example, because coffee is believed to cause sleeplessness and agitation, coffee in the form of a homeopathic medicine could be used to treat people with insomnia or irritability.¹⁸ Various members of the medical community have referred to homeopathy as "quackery,"¹⁹ "nonsense,"²⁰ or even "a sham."²¹

Chiropractic medicine focuses on the musculoskeletal system and the nervous system.²² Chiropractic treatments consist of diagnosis and corresponding manipulations of misalignments of the joints—especially the spinal column—to restore joint mobility and decrease pain.²³ Chiropractic medicine has also been the

12. NAT'L CTR. FOR COMPLEMENTARY & ALTERNATIVE MED., COMPLEMENTARY, ALTERNATIVE, OR INTEGRATIVE HEALTH: WHAT'S IN A NAME? (2014), available at http://nccam.nih.gov/sites/nccam.nih.gov/files/CAM_Basics_What_Are_CAIHA_07-15-2014.2.pdf.

13. See NAT'L CTR. FOR COMPLEMENTARY & ALTERNATIVE MED., WHAT IS COMPLEMENTARY AND ALTERNATIVE MEDICINE (CAM)? 1, available at <http://cim.ucdavis.edu/clubs/camsig/whatiscam.pdf>.

14. *Id.* at 3–4. Other popular alternative care therapies include deep breathing exercises and yoga.

15. *About Homeopathy*, SOC'Y OF HOMEOPATHS, <http://www.homeopathy-soh.org/about-homeopathy/>.

16. *Id.*

17. *Id.*

18. *Id.*

19. BRUCE M. HOOD, *SUPERSENSE: WHY WE BELIEVE IN THE UNBELIEVABLE* 157 (2009).

20. Nick Collins, *Homeopathy Is Nonsense, Says New Chief Scientist*, TELEGRAPH (Apr. 18, 2013, 2:48 PM), <http://www.telegraph.co.uk/health/healthnews/10003680/Homeopathy-is-nonsense-says-new-chief-scientist.html>.

21. Timothy Caulfield & Christen Rachul, *Supported by Science?: What Canadian Naturopaths Advertise to the Public*, ALLERGY, ASTHMA & CLINICAL IMMUNOLOGY, Sept. 15, 2011, at 2, available at <http://www.aacijournal.com/content/pdf/1710-1492-7-14.pdf>.

22. *What Is Chiropractic?*, AM. CHIROPRACTIC ASS'N, http://www.acatoday.org/level2_css.cfm?T1ID=13&T2ID=61.

23. *Id.*

subject of criticism, though that criticism has recently waned.²⁴ For instance, the AMA, whose secretary once referred to chiropractors as “rabid dogs[,] . . . playful and cute, but killers,”²⁵ has recently recommended seeking chiropractic care before pursuing more invasive measures to cure back pain.²⁶

Acupuncture, a traditional Chinese practice, involves the insertion of thin needles just below the surface of the skin at strategic points on an individual’s body.²⁷ Traditional Chinese acupuncturists believe that this technique balances the flow of energy—referred to as qi—through pathways, known as meridians, in the patient’s body.²⁸ The insertion of needles into specific points along these meridians is intended to rebalance the patient’s energy flow and thereby treat pain.²⁹ In comparison, many Western practitioners believe that the placement of the needles stimulates nerves, muscles, and connective tissues, resulting in increased activity of the body’s natural painkillers.³⁰ The use of acupuncture to treat certain conditions has been endorsed by the National Institutes of Health³¹ and the World Health Organization;³² however, some medical professionals object to these endorsements because the research cited in support of acupuncture’s effectiveness is believed to be scientifically flawed.³³

Naturopathy is a form of CAM based on a belief in vitalism, which theorizes that health is “restored by raising the vitality of the patient, initiating the regenerative capacity for self-healing.”³⁴ Naturopathy uses a wide variety of approaches such as changes in nutrition, herbal treatments, manipulations of the body, exercise regimens, and stress-reduction techniques.³⁵ Naturopathic treatments are thus focused on the causes, rather than the symptoms, of the disease and generally avoid the use of any surgery or pharmaceuticals.³⁶ Although naturopaths themselves have

24. James W. DeVocht, *History and Overview of Theories and Methods of Chiropractic: A Counterpoint*, 444 CLINICAL ORTHOPAEDICS & RELATED RES. 243, 243 (2006), available at <http://www.ncbi.nlm.nih.gov/pubmed/16523145>.

25. ABNÉ M. EISENBERG, PRESCRIPTIVE COMMUNICATION FOR THE HEALTHCARE PROVIDER 150 (2012).

26. Denise M. Goodman, *Low Back Pain*, 309 J. AM. MED. ASS’N 1738 (2013), available at http://jama.jamanetwork.com/data/Journals/JAMA/926858/jpg130017_1738_1738.pdf.

27. *Acupuncture: Definition*, MAYO CLINIC (Sept. 3, 2014), <http://www.mayoclinic.org/tests-procedures/acupuncture/basics/definition/PRC-20020778>.

28. *Id.*

29. *Id.*

30. *Id.*

31. Nat’l Insts. of Health, *Acupuncture*, NIH CONSENSUS STATEMENT, Nov. 3–5, 1997, available at <http://consensus.nih.gov/1997/1997Acupuncture107PDF.pdf>.

32. WORLD HEALTH ORG., ACUPUNCTURE: REVIEW AND ANALYSIS OF REPORTS ON CONTROLLED CLINICAL TRIALS 23 (2002), available at <http://apps.who.int/medicinedocs/pdf/s4926e/s4926e.pdf>.

33. See, e.g., SIMON SINGH & EDZARD ERNST, TRICK OR TREATMENT: THE UNDENIABLE FACTS ABOUT ALTERNATIVE MEDICINE 71–73, 83 (2008).

34. JEROME SARRIS & JON WARDLE, CLINICAL NATUROPATHY: AN EVIDENCE-BASED GUIDE TO PRACTICE 3 (2010).

35. *Naturopathic Medicine*, AM. CANCER SOC’Y, <http://www.cancer.org/Treatment/TreatmentsandSideEffects/ComplementaryandAlternativeMedicine/MindBodyandSpirit/naturopathic-medicine> (last modified Jan. 16, 2013).

36. *Id.*

admitted to being “out there,”³⁷ they emphasize that some naturopathic doctors did go to medical school and that their “‘hippie’ medicine works, and what [they] do is becoming less ‘alternative’ and more ‘conventional’ everyday.”³⁸

Massage therapy encompasses a range of different types of techniques; however, the typical massage consists of “long smooth strokes, kneading, and circular movements on superficial layers of muscle using massage lotion or oil.”³⁹ Massage therapy is intended to improve circulation by bringing nutrients, such as oxygen, to body tissue.⁴⁰ Patients seek massages for a variety of common health conditions including back pain, arthritis, carpal tunnel, and headaches.⁴¹ Nevertheless, scientific studies currently “lack the methodological quality to draw firm conclusions regarding massage therapy’s effectiveness.”⁴²

Meditation can carry different meanings depending upon the context. Nevertheless, in regard to the alleged healing powers of meditation, meditators believe the root of any illness is the mind.⁴³ Thus, by “attending to the mind, clearing it of any disturbances, the recovery speeds up.”⁴⁴ Some studies support the proposition that meditation positively impacts mental and physical health, for example, by improving immune function.⁴⁵ Conversely, the National Institutes of Health acknowledges that adverse consequences of meditation can occur.⁴⁶ Therefore, it warns prospective meditators to confirm the qualifications of meditation instructors and urges that meditation should not be used as a “replacement for conventional [health] care or as a reason to postpone seeing a doctor.”⁴⁷

This brief review of various types of CAM illustrates that there are two common perspectives of CAM. The first view, the orthodox perspective, is that CAM practitioners “subscribe[] to absurd theories and inane, sometimes dangerous, therapies”⁴⁸ and that CAM patients suffer from the practitioner’s “ignorance of . . .

37. Michael Stanclift, *You’re What Kind of Doctor?*, HUFFINGTON POST (Oct. 9, 2012, 8:11 AM), http://www.huffingtonpost.com/michael-stanclift-nd/naturopathic-doctors_b_1923371.html.

38. *Id.*

39. Cathy Wong, *10 Most Popular Types of Massage*, ABOUT HEALTH (June 6, 2014), http://altmedicine.about.com/od/massage/a/massage_types.htm.

40. Eileen Cahalane, *Massage To Aid Circulation*, ALIVE (Feb. 2001), http://www.alive.com/articles/view/16868/massage_to_aid_circulation.

41. See generally MARY BETH BRAUN & STEPHANIE J. SIMONSON, INTRODUCTION TO MASSAGE THERAPY (3rd ed. 2014) (describing massage techniques for treating a variety of ailments).

42. Roni Evans, *What Does the Research Say About Massage Therapy?*, TAKING CHARGE YOUR HEALTH & WELLBEING, <http://www.takingcharge.csh.umn.edu/explore-healing-practices/massage-therapy/what-does-research-say-about-massage-therapy> (last modified July 2, 2013).

43. *Healing Power of Meditation*, ART LIVING, <http://www.artofliving.org/healing-power-meditation>.

44. *Id.*

45. E.g., Richard J. Davidson, Jon Kabat-Zinn, Jessica Schumacher, Melissa Rosenkranz, Daniel Muller, Saki F. Santorelli, Ferris Urbanowski, Anne Harrington, Katherine Bonus & John F. Sheridan, *Alterations in Brain and Immune Function Produced by Mindfulness Meditation*, 65 PSYCHOSOMATIC MED. 564 (2003).

46. NAT’L CENTER FOR COMPLEMENTARY & ALTERNATIVE MED., MEDITATION: AN INTRODUCTION 4 (2010), <http://nccam.nih.gov/sites/nccam.nih.gov/files/meditation.pdf>.

47. *Id.*

48. JAMES C. WHORTON, NATURE CURES: THE HISTORY OF ALTERNATIVE MEDICINE IN

science.”⁴⁹ The second view, that of CAM proponents, is that CAM practitioners are “well-intentioned healers”⁵⁰ who are rewarded for their valiant efforts with legal harassment from conventional practitioners who are both “fearful of . . . competition and determined to maintain . . . power.”⁵¹ Consequently, “verbal and political war” has occasionally erupted between CAM supporters and CAM opponents.⁵² Support for the conflicting positions varies wildly depending on the particular alternative treatment at issue.⁵³ Nevertheless, this us-versus-them mentality exists among proponents and opponents of CAM regardless of the legitimacy of such a divide and regardless of the fact that most CAM users take an integrative approach to health care that involves both orthodox and alternative methods of care.⁵⁴

B. The Growth of Complementary and Alternative Medicine

CAM is becoming increasingly prominent in the health-care realm. CAM is widely used and growing in popularity, prompting one scholar to conclude that “[m]edicine in the United States is undergoing a quiet revolution.”⁵⁵ According to a 2008 report prepared by the National Center for Complementary and Alternative Medicine (NCCAM) and the National Center for Health Statistics (part of the Centers for Disease Control and Prevention), the percentage of adults that use some form of CAM climbed from 36% in 2002 to 38.3% in 2007.⁵⁶

The prominence of CAM use in the United States is also reflected in the costs that individuals are willing to pay for CAM products and services. Americans spent \$33.9 billion out of pocket on CAM products and services in 2007, accounting for 11.2% of total out-of-pocket expenditures on health care.⁵⁷ Approximately one-quarter of the total out-of-pocket spending on physician visits was spent on an estimated 354.2 million visits to CAM practitioners such as acupuncturists, chiropractors, and massage therapists.⁵⁸

Patients have reported using complementary and alternative therapies for both health promotion and disease prevention.⁵⁹ Furthermore, patients have reported using CAM because conventional medicine is either too expensive or could not cure their

AMERICA 18 (2002).

49. *Id.*

50. *Id.* at 19.

51. *Id.*

52. *Id.* at 18.

53. *See Medicine and Its Rivals: The Believers*, *ECONOMIST*, Apr. 14, 2012, at 68.

54. Richard Frank, *Alternative Medicine and Cancer: Why Don't Oncologists Get on Board?*, YALE U. PRESS (Feb. 15, 2010), <http://yalepress.typepad.com/fightingcancer/2010/02/alternative-medicine-and-cancer-let-reason-prevail.html>.

55. Aimee Doyle, *Alternative Medicine and Medical Malpractice: Emerging Issues*, 22 J. LEGAL MED. 553, 553 (2001).

56. NAT'L CTR. FOR COMPLEMENTARY & ALTERNATIVE MED., *supra* note 6, at 1.

57. Richard L. Nahin, Patricia M. Barnes, Barbara J. Stussman & Barbara Bloom, *Costs of Complementary and Alternative Medicine (CAM) and Frequency of Visits to CAM Practitioners: United States, 2007*, NAT'L HEALTH STAT. REP. (Nat'l Ctr. for Health Statistics, Hyattsville, Md.), July 30, 2009, at 3, available at <https://nccam.nih.gov/sites/nccam.nih.gov/files/nhsrn18.pdf>.

58. *Id.* at 4.

59. Tais & Oberg, *supra* note 7.

chronic medical conditions or because CAM is “more congruent with their values, beliefs and philosophical orientations towards health and life.”⁶⁰ Nevertheless, most individuals take an integrative approach—one that utilizes CAM techniques *and* conventional treatments—to fulfill their health-care needs.⁶¹

The market has responded to the steady growth and popularity of CAM practices and products. For instance, one 2011 national survey revealed that growing numbers of hospitals offered various alternative health-care services in addition to conventional medical care.⁶² Forty-two percent of hospitals responded that they offer one or more alternative therapies, including chiropractic care, acupuncture, massage therapy, and homeopathy.⁶³ This is a 13.5% increase from the number of hospitals that offered such medical services in 2007.⁶⁴ The introduction of alternative options was largely a response to patient demand.⁶⁵

Fueled by patient demand, as well as a growing body of scientific research demonstrating the efficacy of certain alternative practices, an increasing number of insurance companies are now covering alternative health-care services.⁶⁶ For example, a survey of eighteen major HMOs and insurance providers, such as Aetna, Medicare, Prudential, and Kaiser Permanente, found that fourteen of the providers covered at least eleven of the thirty-four alternative treatments studied.⁶⁷ Another study ranked the complementary and alternative practices that were most commonly covered by employee health plans.⁶⁸ The survey, performed by the International Society of Certified Employee Benefit Specialists, found that eighty-six percent of the plans covered chiropractic care, seventy-five percent covered acupuncture, forty-one percent covered massage therapy, eighteen percent covered naturopathy, and ten percent covered homeopathy.⁶⁹

Some states have even mandated coverage for various CAM approaches. For example, Washington’s Every Category of Provider (ECOP) law requires that insurance companies reimburse all licensed health-care providers for treatment of covered conditions.⁷⁰ Under ECOP, “health carriers shall not exclude any category

60. *Id.* (quoting John A. Astin, *Why Patients Use Alternative Medicine: Results of a National Study*, 279 J. AM. MED. ASS’N 1548, 1548 (1998)).

61. *E.g.*, NAT’L CTR. FOR COMPLEMENTARY & ALTERNATIVE MED, *supra* note 12.

62. Press Release, Am. Hosp. Ass’n. & Samueli Inst., More Hospitals Offering Complementary and Alternative Medicine Services (Sept. 7, 2011), *available at* <http://www.aha.org/presscenter/pressrel/2011/110907-pr-camsurvey.pdf>.

63. *Id.*

64. *See id.*

65. *See* Michelle Andrews, *Hospitals Are Making Room for Alternative Therapies*, L.A. TIMES (Jan. 2, 2012), <http://articles.latimes.com/2012/jan/02/health/la-he-hospitals-alternative-medicine-20120102>.

66. Tais & Oberg, *supra* note 7.

67. Cathy Wong, *12 Questions About Insurance and Complementary/Alternative Medicine*, ABOUT HEALTH (May 29, 2014), <http://altmedicine.about.com/od/alternativemedicinebasics/a/Insurance.htm>.

68. ArcMesa Educators, *Complementary and Alternative Medicine (CAM)—An Introduction*, NURSING LINK, <http://nursinglink.monster.com/training/articles/230-complementary-and-alternative-medicine-cam---an-introduction>.

69. *Id.*

70. Ryan Abbott, *Treating the Health Care Crisis: Complementary and Alternative*

of providers licensed by the state of Washington who provide health care services or care within the scope of their practice for conditions covered by basic health plan (BHP) services.”⁷¹ Furthermore, Washington is not the only state government to mandate coverage of CAM services.⁷²

Attempts to mandate CAM coverage have also been made at the federal level.⁷³ For example, the Federal Acupuncture Coverage Act of 2011 would have provided acupuncture coverage under the Federal Employees Health Benefits Program and Medicare.⁷⁴ More recently, multiple sources have opined that various provisions of the ACA express support for CAM.⁷⁵ Consequently, political and verbal warfare has once again pitted proponents and opponents of CAM against one another. The opponents’ perspective is that greedy CAM practitioners view the ACA as a means to reap large profits by forcing more insurance companies to pay for ineffective treatments.⁷⁶ Conversely, the view expressed by CAM aficionados is that the new law will increase the ability of those from all income levels to gain access to effective medical care that is normally limited to out-of-pocket payments.⁷⁷ Because the impact of various provisions of the ACA on CAM remains largely unknowable, this “war” shows no sign of abating.

C. What Is the Patient Protection and Affordable Care Act?

The ACA was signed into law by President Barack Obama on March 23, 2010.⁷⁸ The legislation encompasses comprehensive health-care reform measures focused on improving the quality and affordability of health care and expanding health-care coverage.⁷⁹ These measures are currently being implemented and will continue to be implemented over the next several years.⁸⁰

Perhaps the best-known aspect of the ACA is its mandate requiring most legal residents to obtain health insurance. The individual mandate requires all individuals subject to the mandate⁸¹ who do not have insurance coverage through an employer,

Medicine for PPACA, 14 DEPAUL J. HEALTH CARE L. 35, 62 (2011).

71. WASH. ADMIN. CODE § 284-43-205 (2014).

72. Abbott, *supra* note 70, at 63 n.152 (citing Carolyn A. Watts, William E. Lafferty & Andrea Corage Baden, *The Effect of Mandating Complementary and Alternative Medicine Services on Insurance Benefits in Washington State*, 10 J. ALTERNATIVE & COMPLEMENTARY MED. 1001, 1002 (2004)) (stating that in 2000, forty-one states mandated coverage of chiropractic services and eight states mandated coverage of acupuncture).

73. *Id.* at 64.

74. Federal Acupuncture Coverage Act of 2011, H.R. 1328, 112th Cong. §§ 2–3.

75. *See infra* Part II.A.

76. E.g., Steven Salzberg, *Alternative Medicine Providers Show Their Greedy Side*, FORBES (Aug. 26, 2013, 8:00 AM), <http://www.forbes.com/sites/stevensalzberg/2013/08/26/alternative-medicine-providers-show-their-greedy-side/>.

77. *See supra* note 10 and accompanying text.

78. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010).

79. Barack Obama, U.S. President, Remarks by the President on the Affordable Care Act and the New Patients’ Bill of Rights (June 22, 2010), *available at* <http://www.whitehouse.gov/the-press-office/remarks-president-affordable-care-act-and-new-patients-bill-rights>.

80. *Id.*

81. The mandate exempts a variety of individuals, including members of certain religious

Medicaid, Medicare, or another public insurance program to obtain a private insurance policy.⁸² All individuals who fail to obtain coverage, with some exceptions,⁸³ will face a tax penalty beginning in 2014.⁸⁴ On June 28, 2012, the U.S. Supreme Court upheld the constitutionality of this mandate.⁸⁵ Consequently, health-insurance coverage is predicted to expand by thirty-two million covered individuals by 2019.⁸⁶

Recognizing the need to increase the quality of health-care coverage, the ACA requires certain insurers to cover “essential health benefits” and limits out-of-pocket costs for such benefits.⁸⁷ States expanding Medicaid coverage must similarly provide these benefits to those newly eligible for Medicaid.⁸⁸ Essential health benefits include ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance-use disorder services, including behavioral-health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventative and wellness services and chronic-disease management; and pediatric services, including oral and vision care.⁸⁹ This package of benefits establishes the minimum benefits that insurance plans must cover; however, the plans may also offer additional benefits.⁹⁰

groups and Native American tribes, undocumented immigrants, incarcerated individuals, those whose incomes are so low they do not have to file taxes, and those for whom health insurance is considered unaffordable (where coverage would exceed eight percent of a family’s income). *ObamaCare Mandate: Exemption and Tax Penalty*, OBAMACARE FACTS, <http://obamacarefacts.com/obamacare-mandate-exemption-penalty.php>. The ACA also provides for subsidies to allow those in lower income brackets to comply with the mandate. Phil Galewitz, *Consumers Guide to Health Reform*, KAISER HEALTH NEWS (Apr. 13, 2010), <http://kaiserhealthnews.org/news/consumers-guide-health-reform-2/>. Moreover, temporary waivers have been issued by the Department of Health and Human Services to exempt a number of companies and organizations from the ACA. Glenn Kessler, *Did Obama Exempt 1,200 Groups, Including Congress, from Obamacare?*, WASH. POST (Oct. 16, 2013), <http://www.washingtonpost.com/blogs/fact-checker/wp/2013/10/16/did-obama-exempt-1200-groups-including-congress-from-obamacare/>.

82. See Galewitz, *supra* note 81.

83. See *supra* note 81.

84. Patient Protection and Affordable Care Act § 1501(b), 26 U.S.C. § 5000A (2012).

85. Nat’l Fed’n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566 (2012).

86. Elenora E. Connors & Lawrence O. Gostin, *Health Care Reform—A Historic Moment in US Social Policy*, 303 J. AM. MED. ASS’N 2521, 2521 (2010).

87. SABRINA CORLETTE, KEVIN W. LUCIA & MAX LEVIN, IMPLEMENTING THE AFFORDABLE CARE ACT: CHOOSING AN ESSENTIAL HEALTH BENEFITS BENCHMARK PLAN (2013), available at http://www.commonwealthfund.org/~media/Files/Publications/Issue%20Brief/2013/Mar/1677_Corlette_implementing_ACA_choosing_essential_hlt_benefits_reform_brief.pdf.

88. As a result of the Supreme Court ruling in *National Federal of Independent Business v. Sebelius*, 132 S. Ct. 2566 (2012), in which the Court deemed the Medicaid expansion aspect of the ACA unconstitutional, states can refuse to expand Medicaid coverage. Multiple states have declined to participate in the vast expansion of Medicaid. Sabrina Tavernise & Robert Gebeloff, *Millions of Poor Are Left Uncovered by Health Law*, N.Y. TIMES, Oct. 3, 2013, at A1 (arguing that many will be stranded without insurance in the twenty-six states that declined to expand Medicaid coverage).

89. Patient Protection and Affordable Care Act § 1302(b), 42 U.S.C. § 18022 (2012).

90. *What Marketplace Health Plans Cover*, HEALTHCARE.GOV, <https://www.healthcare.gov/what-does-marketplace-health-insurance-cover/>.

To implement this requirement, each state selected a “benchmark plan” to serve as a reference point for coverage of essential health benefits.⁹¹ States were required to choose an essential health-benefit benchmark plan by December 26, 2012.⁹² The plan was to be chosen from among the following plans operating within the state: “the three largest small group plans, the three largest state employee health plans, the three largest federal employee health plan options, or the largest HMO offered in the state’s commercial market.”⁹³ If a state failed to choose a benchmark plan, that state defaulted to the largest small-group plan in the state.⁹⁴

States took a variety of approaches to benchmark-plan selection, including intergovernmental decision making, stakeholder engagement, and analysis of benchmark-plan options.⁹⁵ The accepted benchmark plans ultimately defined the essential health benefits that are required to be covered by plans effective in their respective states.⁹⁶ The state benchmark plans are transitional policies, which the U.S. Department of Health and Human Services (HHS) will monitor and potentially revisit in 2016.⁹⁷

II. THE POTENTIAL IMPACTS OF THE ACA ON CAM

A. The ACA’s Potential To Favorably Impact CAM

State benchmark plans vary widely in their coverage of CAM approaches to health care. For example, Washington’s benchmark plan embraces CAM treatments, mandating coverage of *both* chiropractic and acupuncture treatments and even requiring coverage of unlimited visits to an acupuncturist for chemical-dependency treatment.⁹⁸ Indiana covers twelve chiropractic visits per year for spinal manipulation and manual medical-intervention services; however, the plan explicitly excludes services or supplies related to other forms of complementary and alternative medicine, such as acupuncture, homeopathy, naturopathy, massage therapy, electromagnetic therapy, and hypnosis.⁹⁹ The Utah benchmark plan, on the other hand, views CAM treatments unfavorably in their entirety by refusing to mandate

91. CORLETTE ET AL., *supra* note 87, at 2.

92. *Essential Health Benefit (EHB) Benchmark Plans, as of January 3, 2013*, HENRY J. KAISER FAM. FOUND., <http://kff.org/health-reform/state-indicator/ehb-benchmark-plans/>.

93. *Id.*

94. *Id.* (including a table, organized by state, showing which plan was implemented and whether the state chose the plan or defaulted to the plan).

95. CORLETTE ET AL., *supra* note 87, at 2.

96. *Additional Information on Proposed State Essential Health Benefits Benchmark Plans*, CENTER FOR CONSUMER INFO. & INS. OVERSIGHT, <http://www.cms.gov/CCIIO/Resources/Data-Resources/ehb.html>.

97. CORLETTE ET AL., *supra* note 87, at 2.

98. CTRS. FOR MEDICARE & MEDICAID SERVS., WASHINGTON EHB BENCHMARK PLAN 3, available at <http://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/washington-ehb-benchmark-plan.pdf> [hereinafter WASHINGTON PLAN].

99. CTRS. FOR MEDICARE & MEDICAID SERVS., INDIANA EHB BENCHMARK PLAN 11–12, available at <http://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/indiana-ehb-benchmark-plan.pdf> [hereinafter INDIANA PLAN].

coverage of acupuncture or chiropractic visits and excluding homeopathic medicines from coverage.¹⁰⁰

One commentator has referred to the lack of CAM coverage as “an outright violation of the law” that will have to be dealt with.¹⁰¹ In reaching this conclusion, the commentator relies on one clause of the ACA in particular—section 2706¹⁰²—that prohibits discriminating against any health-care provider with a state-recognized license or certification.¹⁰³ CAM proponents thus believe that the law requires integrative health-care professionals, including licensed or certified CAM practitioners, to be included in health-plan coverage. As an illustrative example, proponents argue that the nondiscrimination clause requires a licensed chiropractor who treats a patient for back pain to be reimbursed as would any traditional medical doctor who treats the same symptom.¹⁰⁴

In addition to the nondiscrimination clause of the ACA, commentators believe that further “nods to alternative medicine” are woven throughout other portions of the legislation.¹⁰⁵ For example, they cite section 3502 of the ACA,¹⁰⁶ which focuses on establishing “community health teams to support the patient-centered medical home.”¹⁰⁷ These community health teams are to be interdisciplinary and interprofessional.¹⁰⁸ Thus, the health teams *may* include “doctors of chiropractic” and “licensed complementary and alternative medicine practitioners.”¹⁰⁹

Proponents of CAM have rallied behind these provisions to conclude that the ACA is the latest legitimization of their practices.¹¹⁰ Opponents of CAM, citing the same provisions, have expressed concern that such “legitimization” may result in the government becoming forced to pay for coverage of bogus treatments for vulnerable patients.¹¹¹ The resultant verbal warfare between proponents and opponents of CAM has recently shifted in form to become more political in nature. Section 2706 of the ACA, the nondiscrimination clause, was added to the legislation by Senator Tom

100. CTRS. FOR MEDICARE & MEDICAID SERVS., UTAH EHB BENCHMARK PLAN 4, 6, available at <http://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/utah-ehb-benchmark-plan.pdf> [hereinafter UTAH PLAN].

101. Kaiser Health News & Rao, *supra* note 10.

102. Patient Protection and Affordable Care Act § 2706, 42 U.S.C. § 300gg-5 (2012).

103. Kaiser Health News & Rao, *supra* note 10.

104. *Id.* This nondiscrimination requirement may also create new issues in the area of tort law regarding informed consent. For instance, a surgical center may need to inform a candidate for back surgery of alternative treatments performed by chiropractors or acupuncturists to treat back pain. See generally Peter H. Schuck, *Rethinking Informed Consent*, 103 YALE L.J. 899 (1994) (discussing the doctrinal history of informed consent).

105. Kaiser Health News & Rao, *supra* note 10.

106. § 3502, 42 U.S.C. § 256a-1.

107. *Id.*

108. § 3502(a), 42 U.S.C. § 256a-1(a).

109. § 3502(b)(4), 42 U.S.C. § 256a-1(b)(4).

110. See, e.g., Kaiser Health News & Rao, *supra* note 10.

111. E.g., Salzberg, *supra* note 76 (“Section 2706 opens the door to anyone who provides what they claim is health care—no matter how ridiculous the claim—to file a lawsuit claiming discrimination if an insurance company won’t pay for their services. You could start offering dried bird poop for arthritis, call it ‘avian nature therapy,’ and if an insurer won’t pay for it, you can sue.”).

Harkin (D-IA) following heavy lobbying efforts by the American Chiropractic Association and the Integrative Healthcare Policy Consortium.¹¹² On July 24, 2013, Representative Andy Harris (R-MD) introduced a bill seeking the removal of section 2706 from the ACA.¹¹³ James Madara, on behalf of the AMA, wrote to Representative Harris to express support for the legislative proposal to repeal section 2706.¹¹⁴ Among others, lobbyists for the American Chiropractic Association have responded, stating that the “repressive” bill favoring traditional medical-doctor hegemony is a “sickening exercise, a knee jerk attack against the freedom of the people.”¹¹⁵

This increasingly rancorous commentary surrounding the future impact of the ACA on licensed complementary and alternative medical practitioners largely assumes that the impact will be a positive one. However, the commentary ignores another possibility—the ACA may spell doom for alternative medical practices. A closer look at the legislation demonstrates that this possibility is as likely as, if not more likely than, the possibility that the ACA will favorably affect CAM.

B. The ACA's Potential To Adversely Impact CAM

Despite the alleged nods to alternative medicine sprinkled throughout the ACA, the seemingly pro-CAM provisions will likely prove inconsequential. CAM approaches may play an insignificant role in patient health care under such provisions, which would adversely impact complementary and alternative providers. Moreover, other provisions of the ACA may ultimately slow, or even reverse, the growing demand for CAM services.

The nondiscrimination provision¹¹⁶ included in the ACA may not result in the lucrative impact on alternative-care providers that some commentators have predicted.¹¹⁷ For example, lobbyists may ultimately cause the provision to be repealed.¹¹⁸ Even if repeal is not achieved, concerns that suits will arise even when “ridiculous”¹¹⁹ treatments are not covered are exaggerated. These concerns are overstated for two reasons. First, just because an alternative-care provider is a covered provider does not necessarily mean that all services provided by him or her will be covered. Second, differences in coverage will not always be discriminatory.

112. *Id.*

113. Protect Patient Access to Quality Health Professionals Act of 2013, H.R. 2817, 113th Cong.

114. Letter from James L. Madara, Exec. Vice President & CEO, AMA, to Andy Harris, Representative, U.S. House of Representatives (July 24, 2013), *available at* <http://www.ama-assn.org/resources/doc/washington/non-discrimination-letter-24july2013.pdf>.

115. John Weeks, *Beltway Battle over Patients' Rights to Integrative Medicine and Health*, HUFFINGTON POST (Aug. 12, 2013, 3:40 PM), http://www.huffingtonpost.com/john-weeks/integrative-medicine_b_3732460.html. The bill was referred to committee on July 24, 2013; according to GovTrack, it has a one percent chance of being enacted. *H.R. 2817: Protect Patient Access to Quality Health Professionals Act of 2013*, GOVTRACK.US, <https://www.govtrack.us/congress/bills/113/hr2817> (last updated July 24, 2013).

116. Patient Protection and Affordable Care Act § 2706, 42 U.S.C. § 300gg-5 (2012).

117. *See supra* Part II.A.

118. *See supra* notes 113–14 and accompanying text.

119. *E.g.*, Salzberg, *supra* note 76 (“You could start offering dried bird poop for arthritis, call it ‘avian nature therapy,’ and if an insurer won’t pay for it, you can sue.”).

The ACA only mandates that “essential health benefits” be covered.¹²⁰ Therefore, if a policy does not cover a certain service because it is not a required essential health benefit, then that service is not covered regardless of what type of provider performs that service.¹²¹ For example, preventative services characterized as essential health benefits include abdominal aortic aneurysm one-time screening, alcohol-misuse screening, blood-pressure screening, cholesterol screening, depression screening, diabetes screening, diet counseling, HIV screening, and immunizations and vaccines.¹²² Such procedures are largely beyond the scope of services offered by many CAM providers such as chiropractors and acupuncturists.

Furthermore, even if an essential health benefit is within the scope of an alternative-care provider’s practice, failures to reimburse the provider may still occur. For example, an insurer may ban all coverage of chiropractic or acupuncturist services, as has been done under the transitional essential health benefit state benchmark plans. Moreover, the ACA only covers state-licensed or state-certified health-care providers. Whereas all chiropractors must be licensed to engage in certain practices,¹²³ some states have not required a license to practice naturopathy or homeopathy as long as the provider discloses that he or she will be providing unlicensed healing-arts services.¹²⁴ Therefore, a state may avoid reimbursement of various CAM providers by not providing for licensure or certification under state law—an exercise of the state’s constitutional authority to regulate activities that affect the public health, safety, and welfare of its citizens.¹²⁵

CAM providers may face other legitimate forms of disparate treatment.¹²⁶ For example, the state may require applying practitioners to have particular training, experience, or certification that is much more difficult for an alternative-care provider to obtain than for a traditional medical doctor.¹²⁷ Such actions may not be deemed illegal even if they ultimately adversely affect CAM providers, because these requirements can likely be explained as essential to patient protection if they reasonably relate to the acquisition of safe and efficacious medical treatments.

120. See *supra* notes 87–90 and accompanying text.

121. ARTHUR LERNER, CROWELL & MORING LLP, HEALTH REFORM: PROVIDER NON-DISCRIMINATION PROVISION’S IMPACT ON HEALTH INSURANCE AND ERISA PLANS 10 (2010), available at http://www.azchiropractors.org/file_open.php?id=1320.

122. *Preventive Health Services for Adults*, HEALTHCARE.GOV, <https://www.healthcare.gov/what-are-my-preventive-care-benefits/>.

123. Ruth Sandefur & Ian D. Coulter, *Licensure and Legal Scope of Practice*, in *CHIROPRACTIC IN THE UNITED STATES: TRAINING, PRACTICE, AND RESEARCH* 33, 36–37 (Daniel C. Cherkin & Robert D. Mootz eds., 1997).

124. E.g., NATUROPATHIC MED. COMM., CAL. DEP’T OF CONSUMER AFFAIRS, FREQUENTLY ASKED QUESTIONS: UNLICENSED NATUROPATHIC OR HOMEOPATHIC PRACTICE (2013), available at http://www.naturopathic.ca.gov/consumers/faq_unlicensed.pdf.

125. See, e.g., *Goldfarb v. Va. State Bar*, 421 U.S. 773, 792 (1975) (recognizing that states “have a compelling interest in the practice of professions within their boundaries, and that as part of their power to protect the public health, safety, and other valid interests they have broad power to establish standards for licensing practitioners and regulating the practice of professions”).

126. See *id.*

127. See *id.*; see also Paul B. Ginsburg & Ernest Moy, *Physician Licensure and the Quality of Care: The Role of New Information Technologies*, REG.: CATO REV. BUS. & GOV’T., Fall 1992, at 32.

The nondiscrimination clause seems consistent with this determination, considering that its terms allow insurers to vary reimbursement based on “quality or performance measures.”¹²⁸ Those CAM practices that cannot be scientifically proven to be as efficacious as mainstream practices could, therefore, be reimbursed at lower rates. In short, CAM proponents’ enthusiasm that section 2706 will end all disparate treatment of CAM providers and ultimately lead to a wide acceptance of alternative treatments¹²⁹ is, at the very least, overstated.

Proponents’ enthusiasm surrounding the mention of alternative health-care providers in the “health teams”¹³⁰ provisions of the ACA is also questionable when considered along with other provisions of the ACA. First, selection of alternative health-care providers as part of such a “team” is discretionary.¹³¹ Second, the health-care team must provide “safe and high-quality care through evidence-informed medicine,”¹³² and services must be “appropriate” and “cost-effective.”¹³³ Considerations of cost effectiveness¹³⁴ and evidence of medicinal value¹³⁵ (or, more likely, a lack thereof) will probably result in many alternative-care methods being exempted from health-insurance coverage regardless of whether they are part of a health team’s prescribed treatments.

Not only are the supposedly pro-alternative-care provisions of the ACA less significant than some commentators assert, other provisions of the ACA may adversely affect complementary- and alternative-care providers. The provisions that

128. Patient Protection and Affordable Care Act § 2706(a), 42 U.S.C. § 300gg-5(a) (2012). There are a number of methods that have been used in the past in defining “pay for performance.” Michael G. Trisolini, *Introduction to Pay for Performance*, in *PAY FOR PERFORMANCE IN HEALTH CARE: METHODS AND APPROACHES* 7, 14 (Jerry Cromwell et al. eds., 2011). Programs that “pay for quality” assess quality by quantitatively determining successful outcomes of various treatments. *Id.* Programs that “pay for reporting” allow reimbursement for providers who establish a designed reporting system. *Id.* This system often becomes a “pay for quality” system once providers become comfortable with the reporting system. *Id.* Programs that “pay for efficiency” reward cost reduction and containment. *Id.* Lastly, a “pay for value” system combines quality and cost measures. *Id.* Regardless of the quality and performance measurements that the ACA ultimately requires, each of these programs of pay often reimburses physicians that can demonstrate successful clinical outcomes; a high level of patient safety; cost effectiveness; and the adherence to evidence-based medical practice, which involves following guidelines produced in peer-reviewed articles or that are endorsed by national accreditation organizations. Gregory C. Pope, *Overview of Pay for Performance Models and Issues*, in *PAY FOR PERFORMANCE IN HEALTH CARE*, *supra*, at 33, 34–35, 38.

129. Kaiser Health News & Rao, *supra* note 10.

130. *See supra* notes 106–10 and accompanying text.

131. § 3502(b)(4), 42 U.S.C. § 256a-1(b)(4).

132. § 3502(c), 42 U.S.C. § 256a-1(c) (emphasis added).

133. *Id.*

134. *See, e.g.*, Patricia M. Herman, Benjamin M. Craig & Opher Caspi, *Is Complementary and Alternative Medicine (CAM) Cost-Effective? A Systematic Review*, *BMC COMPLEMENTARY & ALTERNATIVE MED.*, Jun. 2, 2005, available at <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1182346/pdf/1472-6882-5-11.pdf> (introducing economic evaluation of complementary and alternative medicine).

135. *See, e.g.*, PAUL A. OFFIT, *DO YOU BELIEVE IN MAGIC? THE SENSE AND NONSENSE OF ALTERNATIVE MEDICINE* (2013) (arguing that although some alternative therapies are helpful due to the placebo response, many alternative therapies are ineffective, expensive, and even deadly).

have the potential to eliminate, or severely curtail, alternative-care providers from being included in insurance coverage are the ACA's provisions regarding essential health benefits. Insurance policies must cover at least ten categories of essential health benefits¹³⁶ in order to be certified under the ACA and offered through state-based "purchasing exchanges."¹³⁷ Congress charged the HHS to further define these categories of patient care.¹³⁸

The HHS has, at least currently, allowed state governments to formulate their own minimum requirements for a health-insurance plan by choosing from an existing plan offered in their states—the aforementioned state benchmark plans.¹³⁹ As previously indicated, states have demonstrated a varying degree of willingness to cover CAM.¹⁴⁰ Some states, such as Utah, explicitly exclude all alternative-care practices, whereas multiple other states, such as Indiana, explicitly exclude virtually all alternative practices except chiropractic care.¹⁴¹ Therefore, many of the currently adopted plans will not favorably affect complementary and alternative medical practitioners.

This unfavorable treatment of alternative health care may be exacerbated by the HHS's ability to revisit the benchmark issue in 2016.¹⁴² The ACA requires the HHS to review and make necessary updates to the essential health-care benefits.¹⁴³ During the review process, "medical evidence" and "scientific advancement" *must* be considered.¹⁴⁴ Moreover, upon revisiting the essential health benefits, any particular state-mandated benefit that is not characterized as an essential health benefit must be excluded from federal coverage.¹⁴⁵

The Institute of Medicine (IOM) was charged with assisting the HHS in defining essential health benefits by proposing criteria that should be used to decide which benefits are most important for coverage.¹⁴⁶ The IOM's recommendations have, thus far, specified that only medically necessary services should be covered¹⁴⁷ and that covered services need to be based on credible evidence of effectiveness.¹⁴⁸ Similarly, the IOM's criteria for individual services state that the services should be supported by a sufficient evidence base,¹⁴⁹ and any update to essential health benefits must be data driven, with evaluations of care based, in part, upon "objective clinical evidence and actuarial reviews."¹⁵⁰

136. *See supra* note 89 and accompanying text.

137. INST. OF MED. OF THE NAT'L ACADS., *ESSENTIAL HEALTH BENEFITS: BALANCING COVERAGE AND COSTS*, at xi (Cheryl Ulmer et al. eds., 2011).

138. *Id.*

139. *See supra* notes 87–97 and accompanying text.

140. *See supra* text accompanying notes 98–100.

141. *Compare* UTAH PLAN, *supra* note 100, at 4, 6, *with* INDIANA PLAN, *supra* note 99, at 12.

142. *See supra* note 97 and accompanying text.

143. Patient Protection and Affordable Care Act § 1302(b)(4)(G), 42 U.S.C. § 18022(b)(4)(G) (2012).

144. § 1302(b)(4)(G)(ii), 42 U.S.C. § 18022(b)(4)(G)(ii).

145. *See* INST. OF MED. OF THE NAT'L ACADS., *supra* note 137, at 88.

146. *Id.* at 79.

147. *See id.* at 64.

148. *See id.* at 150.

149. *Id.* at 52.

150. *Health Law Update—October 27, 2011*, BAKERHOSTETLER (Oct. 27, 2011), <http://www.bakerlaw.com/health-law-update-10-27-2011/> [hereinafter *Health Law Update*].

The alternative health techniques or procedures to be covered by some of the state-mandated benchmark plans would likely have to survive this rigorous level of scientific scrutiny in order to be considered essential health benefits. Many such techniques and procedures will be unable to satisfy this standard.¹⁵¹ Moreover, the ACA prevents federal subsidization of state-mandated procedures or treatments that exceed the essential health benefits as defined by the HHS.¹⁵² In other words, states, rather than the federal government, would be responsible for subsidizing those treatments that are mandated but not deemed essential health benefits for individuals who cannot afford the premiums on plans encompassing such treatments.¹⁵³ From an economic standpoint, this is a disincentive for states to design or keep mandates that do not fall within the HHS's definition of an essential health benefit. Therefore, as the ACA matures past its implementation stage, there is a possibility that alternative-care practices, especially those lacking sufficient evidence of medical effectiveness, will continue to be eliminated from coverage.

This elimination from coverage could ultimately spell disaster for the growth of alternative health-care practices that are not considered, according to orthodox Western medical standards, "evidence-based."¹⁵⁴ This issue may be compounded by demographic characteristics associated with the use of CAM. Many low-income and uninsured adults cite lower cost as a reason for seeking alternative medical treatments.¹⁵⁵ Although some individuals cited other reasons, such as congruence with their philosophical orientation toward health care or lack of conventional medicine to cure their specific condition, uninsured individuals were four times more likely to be CAM users than their insured counterparts.¹⁵⁶ These individuals, likely to become insured pursuant to the ACA's individual mandate, may switch to conventional treatments as those treatments become more affordable. If these individuals replace their alternative-care practitioners with conventional medical providers, demand for alternative care may ultimately decrease among the largest demographic of individuals that seek alternative care today. Therefore, the ACA may

151. See generally SINGH & ERNST, *supra* note 33 (providing an analysis of the benefits and dangers of more than thirty alternative treatments, including acupuncture, homeopathy, aromatherapy, reflexology, herbal medicines, and chiropractic); Deborah Cohen, *Scientists Fear That Libel Ruling on Chiropractic Will Inhibit Debate*, 338 BRIT. MED. J. 1290 (2009) (demonstrating differences of opinion surrounding efficacy of chiropractic); Matias Vested Madsen, Peter C. Gøtzsche & Asbjørn Hróbjartsson, *Acupuncture Treatment for Pain: Systematic Review of Randomised Clinical Trials with Acupuncture, Placebo Acupuncture, and No Acupuncture Groups*, 338 BRIT. MED. J. 330 (2009) (demonstrating differences of opinion surrounding efficacy of acupuncture).

152. Amanda Cassidy, *Essential Health Benefits*, HEALTH POLICY BRIEF (HealthAffairs/Robert Wood Johnson Found., Bethesda, Md.), May 2, 2013, at 3, available at http://healthaffairs.org/healthpolicybriefs/brief_pdfs/healthpolicybrief_91.pdf.

153. See *id.*

154. See Mark R. Tonelli & Timothy C. Callahan, *Why Alternative Medicine Cannot Be Evidence-Based*, 76 ACAD. MED. 1213, 1213 (2001).

155. See Ha T. Tu & J. Lee Hargraves, *High Cost of Medical Care Prompts Consumers To Seek Alternatives*, DATA BULLETIN (Ctr. For Studying Health Sys. Change, Wash., D.C.), Dec. 2004, available at <http://www.hschange.com/CONTENT/722/722.pdf> (citing 2002 National Health Interview Survey).

156. Tais & Oberg, *supra* note 7.

not only result in little coverage of alternative-care practices but may even slow the general demand for such practices.

An argument of similar import, but of perhaps less strength, arises out of the prediction that the ACA will ultimately lead to the demise of health savings accounts (HSAs).¹⁵⁷ Because many consumers rely on HSAs to cover the cost of their complementary and alternative treatments, the demand for these treatments would consequently suffer.¹⁵⁸ The primary concern is that HSAs cannot meet the medical loss ratio provisions in the ACA.¹⁵⁹ The ACA requires that insurance plans maintain a medical loss ratio of eighty-five percent for large-group plans and eighty percent for small-group and individual plans.¹⁶⁰ The medical loss ratio is calculated by determining what percentage of insurance premiums is allocated to qualifying medical expenses.¹⁶¹ A failure to maintain the prescribed percentage results in a mandatory refund to the policyholder of the excess premiums paid.¹⁶²

Any payments made by plan policyholders to meet the high deductibles associated with HSAs do not count as qualifying medical expenses.¹⁶³ Generally speaking, only five percent of those with HSAs have claims paid by their insurers in any given year that would count toward the medical loss ratio.¹⁶⁴ The other ninety-five percent would thus necessitate huge refunds from insurance companies to policyholders.¹⁶⁵ Given the low profitability of such plans after the imposition of the ACA, HSAs will likely “disappear from the insurance marketplace,” leaving those who depended upon HSAs to pay for their complementary and alternative care without a critical source of funds to pay for such care.¹⁶⁶ The ultimate effect may be a decreased demand for complementary and alternative health care.

157. An HSA is a savings account associated with high-deductible health insurance coverage that allows policyholders to save money tax free for medical expenses. *Health Savings Accounts: Is an HSA Right for You?*, MAYO CLINIC (Apr. 13, 2013), <http://www.mayoclinic.com/health/health-savings-accounts/GA00053>.

158. See *New Regulations Threaten Insurance for CAM Patients*, ALLIANCE FOR NAT. HEALTH (Jan. 10, 2012), <http://www.anh-usa.org/new-regulations-threaten-insurance-for-cam-patients/> [hereinafter *New Regulations*]. Nevertheless, more recent commentary on the subject posits that HSAs are likely to survive under the ACA. The commentary suggest that HSAs will survive because they will meet the “bronze requirement” of health coverage allowed to be offered on health-insurance exchanges. See Merrill Matthews, *Health Savings Accounts Will Survive ObamaCare—At Least for Now*, FORBES (Mar. 27, 2013, 12:29 PM), <http://www.forbes.com/sites/merrillmatthews/2013/03/27/health-savings-accounts-will-survive-obamacare-at-least-for-now/>.

159. *New Regulations*, *supra* note 158.

160. Whitney R. Johnson, *The Impact of Health Reform on HSAs*, 27 BENEFITS Q., no. 3, 2011, at 45, 49.

161. *Id.*

162. *Id.*

163. *Id.*

164. *The New Medical Loss Ratio Rule Means No Bronze Plans, and No HSAs in Obamacare Exchanges*, HSA COALITION (2008), <http://www.hsacoalition.org/issue-analysis/the-new-medical-loss-ratio-rule-means-no-bronze-plans-in-obamacare/>.

165. See Johnson, *supra* note 160, at 49–50.

166. See *New Regulations*, *supra* note 158.

III. FUTURE OUTLOOK

A. The Importance of Advocacy

The subtle nuances of the various provisions of the ACA mentioned in this Note and the ways in which these provisions will be interpreted and enforced remain to be seen. The ACA, with its various nods to alternative health care, gives proponents of alternative care a foothold in gaining inclusion in the future of insured health care.¹⁶⁷ Even so there are also mechanisms in place in the ACA that may prevent many alternative-care practices from being covered.¹⁶⁸ With the nondiscrimination provision yet to be fully defined, the primary lesson for both proponents and opponents of CAM is that the current state of flux has produced an important opportunity for voices to be heard.

For proponents of alternative health care, this is a critical opportunity to engage in discourse with naysayers and to advocate for their inclusion in coverage pursuant to the ACA. For example, proponents should join together in their respective professional associations, continue to lobby against the suggested repeal of the nondiscrimination clause, and demonstrate the medical efficacy and cost effectiveness of various alternative practices. By joining together as their own advocates or building partnerships with mainstream practitioners, alternative-care proponents could shape the ultimate implementation of the ACA so that it has a favorable impact on CAM.

Similarly, for opponents of alternative health care, this is a critical opportunity to engage in discourse with those who believe CAM is a valid substitute for conventional medical practices. For example, opponents should join together in their respective professional associations, continue to support the bill seeking the repeal of the nondiscrimination clause, and present existing evidence that many alternative-care practices are neither cost effective nor medically efficacious under the IOM's proposed standards for inclusion as an essential health benefit. By joining together, opponents of CAM could ultimately prevent the ACA from benefiting the field of complementary and alternative health care.

B. Suggested Interpretation of the ACA's Nondiscrimination Provision

Section 2706 of the ACA states that a "group health plan and a health insurance issuer offering group or individual health insurance coverage shall not discriminate with respect to participation under the plan or coverage against any health care provider who is acting within the scope of that provider's license or certification under applicable State law."¹⁶⁹ The U.S. Departments of Labor, Health and Human Services, and the Treasury have not released regulations addressing this section and do not expect to do so in the near future.¹⁷⁰ Rather, the statutory language is allegedly

167. See *infra* Part II.A.

168. See *infra* Part II.B.

169. Patient Protection and Affordable Care Act § 2706(a), 42 U.S.C. § 300gg-5(a) (2012).

170. U.S. Depts. of Labor, Health & Human Servs. & Treasury, *FAQs About the Affordable Care Act Implementation Part XV*, U.S. DEP'T LAB. (Apr. 29, 2013), <http://www.dol.gov/ebsa/faqs/faq-aca15.html>.

“self-implementing”¹⁷¹—group health plans and health-insurance issuers offering group or individual coverage are expected to implement section 2706 using “a good faith, reasonable interpretation of the law.”¹⁷² The principal issue that should be addressed in order to properly interpret section 2706 is how the term “discriminate” should be defined. Policymakers and regulators should interpret and enforce the section in a manner that takes both CAM opponents’ and CAM proponents’ views into consideration.

The plain language of the statute and the legislative history of the section, extolled by CAM proponents, support the conclusion that when a CAM provider treats a health condition covered by an insurance plan, the provider is entitled to receive reimbursement for the treatment from the insurance company as long as the treatment is within the provider’s scope of practice and the provider is licensed within the state.¹⁷³ Under this view, insurance plans perpetuate discrimination against CAM providers if they contain design features that explicitly exclude CAM providers from even the possibility of becoming eligible for reimbursement. As an illustration, the Utah benchmark plan explicitly excludes coverage of acupuncture and chiropractic visits.¹⁷⁴ Yet, Utah issues state licenses to practice both acupuncture¹⁷⁵ and chiropractic medicine.¹⁷⁶ Pursuant to section 2706, these licensed CAM providers should be eligible for reimbursement when they treat health conditions covered by an insurance plan as long as that treatment is within the provider’s scope of practice.¹⁷⁷ Consequently, federal and state regulators should address such discriminatory design by eliminating blanket bans on reimbursement to CAM providers.

On the other hand, as CAM opponents may espouse, the nondiscrimination clause should not be interpreted to proscribe *all* inequalities encountered by CAM practitioners. For example, section 2706 itself does not prevent “a group health plan, a health insurance issuer, or the Secretary from establishing varying reimbursement rates based on quality or performance measures.”¹⁷⁸ In other words, CAM providers can be reimbursed at lower rates if they are deemed to be less efficacious than orthodox medical providers.

Differing reimbursement rates between CAM practitioners and orthodox medical practitioners are not the only type of inequality that should be permissible under section 2706. The broader goal of the ACA is to ensure affordable and effective health care for Americans.¹⁷⁹ Health-care practices compatible with this framework must presumably be cost effective, medically necessary, and supported by credible

171. *Id.*

172. *Id.*

173. *See supra* Part II.A.

174. *See* UTAH PLAN, *supra* note 100, at 4.

175. *See, e.g.*, UTAH CODE ANN. § 58-72-101 to -601 (LexisNexis 2012) (Acupuncture Licensing Act); *Licensed Acupuncturist*, UTAH DIVISION OCCUPATIONAL & PROF. LICENSING, <http://www.dopl.utah.gov/licensing/acupuncture.html>.

176. *See, e.g.*, UTAH CODE ANN. § 58-73-101 to -701 (LexisNexis 2012) (Chiropractic Physician Practice Act); *Chiropractic*, UTAH DIVISION OCCUPATIONAL & PROF. LICENSING, <http://www.dopl.utah.gov/licensing/chiropractic.html>.

177. *See* Patient Protection and Affordable Care Act § 2706(a), 42 U.S.C. § 300gg-5(a) (2012).

178. *Id.*

179. *See supra* note 87 and accompanying text.

evidence of effectiveness. Therefore, inequalities between orthodox practices and CAM practices that arise as a result of a given CAM technique's lack of cost effectiveness, medical necessity, or evidence base should not be deemed discriminatory. Rather, the inequality would be wholly consistent with the general purposes of the ACA.

For example, although not yet of binding force, the IOM recommended to the HHS that covered essential health benefits must be characterized by "objective clinical evidence."¹⁸⁰ The scientific underpinnings of many CAM treatments are questionable.¹⁸¹ If a given CAM treatment cannot be proven to be clinically effective to even a minimal degree, then that treatment should be eliminated from coverage. Accordingly, insurance providers should not be required to reimburse CAM practitioners for providing such services to policyholders. Moreover, if the effectiveness of a treatment is reasonable yet suspect, such a finding would at least warrant a lower reimbursement rate for the treatment. This conclusion is warranted based upon the ACA's broader goals of providing cost-effective, efficacious medical treatment.

Although some benchmark plans allow for unlimited visits to various CAM providers for certain treatments,¹⁸² medical necessity and cost effectiveness may also warrant caps on the number of visits to such providers. For instance, Indiana's benchmark plan will only cover twelve chiropractic visits per year for spinal manipulation and manual medical-intervention services.¹⁸³ Even if visits to orthodox practitioners are not subject to such a cap, caps should not be considered discriminatory if supported by clinical evidence that the cap is based on medical necessity or cost effectiveness. Therefore, under the ACA, limits on the number of visits will, and should, be allowable rather than deemed discriminatory under section 2706.

Furthermore, the nondiscrimination policy of section 2706 only applies to licensed or certified CAM providers.¹⁸⁴ If the provider is not licensed or is not providing a service that is within the scope of that license, then he or she is not eligible for reimbursement under the provision.¹⁸⁵ It is within a state's authority to choose not to license varying CAM providers.¹⁸⁶ Even in instances when CAM practitioners are able to receive licenses, states may require applying practitioners to have particular training, experience, or certification that is more difficult for an alternative-care provider to obtain than for an orthodox medical practitioner. As in the context of capping the number of visits, strengthening state-licensing requirements can be explained as essential to the acquisition of safe and efficacious medical treatment rather than discrimination against CAM practitioners.

In sum, rather than banning coverage outright, states may presumably cap the number of visits to CAM providers or develop stricter licensing requirements in order to diminish insurance coverage of CAM. Similarly, lower reimbursement rates of

180. *Health Law Update*, *supra* note 150.

181. *See supra* Part I.A.

182. *See, e.g.*, WASHINGTON PLAN, *supra* note 98, at 3.

183. *See* INDIANA PLAN, *supra* note 99, at 11.

184. *See* Patient Protection and Affordable Care Act § 2706, 42 U.S.C. § 300gg-5 (2012).

185. *See id.*

186. *See* Goldfarb v. Va. State Bar, 421 U.S. 773, 792 (1975); *see also supra* note 125 and accompanying text.

CAM providers and their treatments are warranted if these providers' services are not as cost effective, medically necessary, or scientifically efficacious as orthodox services. Such actions seem to be perfectly legal under the requirements of the ACA, which emphasizes the improvement of the affordability and adequacy of health care.

Nevertheless, making access to CAM providers prohibitively difficult or preventing meaningful reimbursement of CAM providers would violate the spirit of the nondiscrimination provision. As an illustration, if an insurance policy marketed on the health-care exchange limited the number of visits to all CAM practitioners to an unreasonably low number and reimbursed all CAM practitioners at arbitrarily low rates compared to their orthodox counterparts, then there would be a colorable claim that the policy discriminates against CAM practitioners in violation of section 2706. However, without this degree of disparate treatment of CAM practitioners, one would likely find it difficult to argue that insurance policy provisions were intended to, and did in fact, unjustly discriminate against CAM practitioners. Rather, differential treatment between orthodox medical providers and CAM providers is likely justified as a legitimate choice to provide cost-effective, scientifically credible health care to Americans under the ACA.

This Note's suggested interpretation of the nondiscrimination provision would not result in the windfall for alternative-care providers that some commentators have predicted.¹⁸⁷ While CAM providers should not be explicitly excluded from coverage, some of their services should be if the efficacy of those services cannot be clinically proven. CAM providers may also be reimbursed at lower rates and have their visits capped if clinical studies demonstrate that CAM treatments are significantly less efficacious than orthodox treatments. Nevertheless, the mere inclusion of CAM providers in plans purchased pursuant to the ACA bodes well for CAM providers. Inclusion enables them to demonstrate that their treatments are as credible as those of their orthodox counterparts and that they should be reimbursed accordingly.

Therefore, the ACA has at least given CAM practitioners a seat at the table, even if it has not provided them with something to eat—yet. Such inclusion is an unprecedented opportunity. As one commentator stated, “I think [CAM practitioners are] getting more of a voice. Is it that we’re taking over the place? Not at all! But that’s OK, we’re just happy to be part of the conversation.”¹⁸⁸

CONCLUSION

To the dismay of some advocates for mainstream medicine, CAM has recently attracted swathes of Americans who are choosing to take a more integrative approach to health care. The definitive impact of the ACA on this growing field of practice remains largely unknown. This uncertainty surrounding the future of health-care coverage has created a breeding ground for the verbal and political warfare to resume between proponents and opponents of alternative medical practices. This Note has argued that the language of and discourse surrounding the ACA has armed both CAM proponents and opponents with valid arguments and lobbying foci to assist in their efforts.

187. *See supra* Part II.A.

188. Gaby Zastrocky, *Healthcare Reform “No Birthday” for Holistic Medicine*, HOLISTIC PRIMARY CARE, Winter 2012, at 1, 13.

Yet, what is at stake in these “us-versus-them” battles is more than patient choice. The outcome of this verbal and political warfare could ultimately make the best practitioners of our time, from *whatever* disciplines, more available to provide optimal and affordable patient care.¹⁸⁹ Therefore, the formal statutory interpretation of the ACA’s nondiscrimination provision should pay heed to both positions—as stories like that of Diane Klenke demonstrate, it is “time to give collaboration, inclusion and shared leadership a chance.”¹⁹⁰

189. Weeks, *supra* note 115.

190. *Id.*